

1 KAMALA D. HARRIS
Attorney General of California
2 GLORIA A. BARRIOS
Supervising Deputy Attorney General
3 LINDA L. SUN
Deputy Attorney General
4 State Bar No. 207108
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-6375
6 Facsimile: (213) 897-2804
Attorneys for Complainant
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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **MARY EDEN ROBLES,**
14 **AKA MARY EDEN V. MONROYO**
26420 Santa Rosa Drive
Moreno Valley, CA 92555

15 **Registered Nurse License No. 323699**

16 Respondent.

Case No. **2013-193**

A C C U S A T I O N

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18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22 Consumer Affairs.

23 2. On or about November 30, 1980, the Board of Registered Nursing (Board) issued
24 Registered Nurse License Number 323699 to Mary Eden Robles aka Mary Eden V. Monroyo
25 (Respondent). The Registered Nurse License was in full force and effect at all times relevant to
26 the charges brought herein and will expire on October 31, 2012, unless renewed.

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1 9. California Code of Regulations, title 16, section 1443, provides:

2 As used in Section 2761 of the code, "incompetence" means the lack of
3 possession of or the failure to exercise that degree of learning, skill, care and
4 experience ordinarily possessed and exercised by a competent registered nurse as
described in Section 1443.5.

5 10. California Code of Regulations, title 16, section 1443.5, provides:

6 A registered nurse shall be considered to be competent when he/she
7 consistently demonstrates the ability to transfer scientific knowledge from social,
biological and physical sciences in applying the nursing process, as follows:

8 (1) Formulates a nursing diagnosis through observation of the client's
9 physical condition and behavior, and through interpretation of information
obtained from the client and others, including the health team.

10 (2) Formulates a care plan, in collaboration with the client, which ensures
11 that direct and indirect nursing care services provide for the client's safety,
12 comfort, hygiene, and protection, and for disease prevention and restorative
measures.

13 (3) Performs skills essential to the kind of nursing action to be taken,
14 explains the health treatment to the client and family and teaches the client
and family how to care for the client's health needs.

15 (4) Delegates tasks to subordinates based on the legal scopes of practice of
16 the subordinates and on the preparation and capability needed in the tasks to
17 be delegated, and effectively supervises nursing care being given by
subordinates.

18 (5) Evaluates the effectiveness of the care plan through observation of the
19 client's physical condition and behavior, signs and symptoms of illness, and
20 reactions to treatment and through communication with the client and health
team members, and modifies the plan as needed.

21 (6) Acts as the client's advocate, as circumstances require, by initiating
22 action to improve health care or to change decisions or activities which are
23 against the interests or wishes of the client, and by giving the client the
24 opportunity to make informed decisions about health care before it is
provided.

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1 **COST RECOVERY**

2 11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
3 administrative law judge to direct a licensee found to have committed a violation or violations of
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
5 enforcement of the case.

6 **DRUG DEFINITION**

7 12. Cardizem is the brand name of the drug Diltiazem, which is used to treat
8 hypertension, angina and certain heart rhythm disorders. Diltiazem is a calcium-channel blocker
9 used to relax the blood vessels and increase the supply of blood and oxygen to the heart. It is not
10 a scheduled drug, but can be fatal if an overdose is taken. It is a dangerous drug pursuant to
11 Business and Professions Code section 4022.

12 **FACTUAL ALLEGATIONS**

13 13. In 2007, Respondent began working as a registered nurse on the night shift at Promise
14 Hospital of East Los Angeles (Promise Hospital). Thereafter, at times, she also functioned as the
15 Relief House Supervisor on the night shift. As the Relief House Supervisor, Respondent had the
16 ability to override medication profiles contained in the Pyxis¹ machine by using her individual
17 access code. Promise Hospital policy requires nurses not to reveal their personal access code to
18 anyone, for patient safety reasons. Whenever a nurse needs to override the Pyxis machine to
19 obtain additional medication, a Nursing Supervisor for that specific shift is mandated to witness
20 the override.

21 14. On January 26, 2010, Patient A, a 92-year old female, was admitted to Promise
22 Hospital due to respiratory failure, pneumonia, congestive heart failure, and cardiac arrhythmia,
23 among other things.

24
25 ¹ A Pyxis machine is a medication dispensing station contained in most hospitals. Access
26 to the machine requires that the user insert a personalized secret passcode to access the
27 medication. In some hospitals, fingerprints are used instead of passcodes. Override medications
28 are medications that can be accessed by nursing staff from the Pyxis machine before review of an
order by the pharmacist. Overrides were only permitted on night shifts at Promise Hospital and
only with supervisor approval and assistance.

1 15. On March 22, 2010, Patient A's physician ordered 60 mg of Cardizem to be
2 administered to Patient A every eight hours. Licensed vocational nurse LV, correctly wrote the
3 order for **60 mg** of Cardizem every eight hours on the Physician Order Sheet, but incorrectly
4 transcribed the order as **600 mg** on the Medication Administration Record (MAR). Although
5 Nurse LV incorrectly transcribed the dosage, she gave the patient the correct dosage of 60 mg on
6 March 22, 2010.

7 16. At approximately midnight on March 23, 2010, the hospital pharmacy audited all
8 patient medication orders. In this case, the pharmacy caught the transcription error on the MAR
9 and corrected the order to 60 mg Cardizem. However, the night shift licensed vocational nurse
10 MM, crossed out the pharmacy's corrected order and wrote in the wrong dosage of 600 mg from
11 the MAR, without checking the doctor's order sheet.

12 17. Between March 22- 24, 2010, MM administered four doses of 600 mg of Cardizem to
13 Patient A. The first dose was dispensed and administered on March 22, 2010 at approximately
14 8:40 p.m. The second dose was dispensed and administered on March 23, 2010 at approximately
15 4:58 a.m. The third dose was dispensed and administered on March 23, 2010 at approximately
16 7:58 p.m. The last dose was dispensed and administered on March 24, 2010 at approximately
17 4:39 a.m. Approximately six hours after receiving the last dose, Patient A's heart rate stopped
18 and a code blue was called. Patient A was revived, but required intubation and was transferred to
19 the Intensive Care Unit.

20 18. On or about March 23-24, 2010, Respondent used her Pyxis access code on three
21 separate occasions to override the system and assist M.M. in obtaining the 600 mg doses of
22 Cardizem. The Pyxis printout confirms that Respondent's passcode was used at 4:58 a.m. and
23 7:58 p.m. on March 23, 2010, and at 4:39 a.m. on March 24, 2010, to withdraw 600 mg of
24 Cardizem.

25 19. Respondent was terminated from employment at Promise Hospital following this
26 incident.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct – Gross Negligence)**

3 20. Respondent is subject to disciplinary action under Code section 2761, subdivision
4 (a)(1) on the grounds of unprofessional conduct that during her employment at Promise Hospital,
5 Respondent was grossly negligent when she repeatedly failed to provide nursing care as required
6 and/or failed to provide care or exercise ordinary precaution when she knew or should have
7 known failure to do so could have jeopardized Patient A's health or life as follows:

8 a. Respondent performed Pyxis overrides on three separate occasions without checking
9 the physician's order to ensure that the overrides were appropriate;

10 b. Respondent violated hospital policy by failing to observe MM withdraw the
11 medication from the Pyxis machine; and

12 c. In the alternative, Respondent failed to secure her passcode so that it could not be
13 used by others.

14 21. Complainant refers to and incorporates all the allegations contained in paragraphs 13
15 19, as though set forth fully.

16 **SECOND CAUSE FOR DISCIPLINE**

17 **(Unprofessional Conduct – Incompetence)**

18 22. Respondent is subject to disciplinary action for unprofessional conduct under section
19 2761(a)(1) of the Code in that during her employment at Promise Hospital, Respondent
20 demonstrated incompetence, as she failed to exercise the degree of learning, skill, care and
21 experience ordinarily possessed and exercised by a competent registered nurse, as follows:

22 a. Respondent performed Pyxis overrides on three separate occasions without checking
23 the physician's order to ensure that the overrides were appropriate;

24 b. Respondent violated hospital policy by failing to observe MM, LVN withdraw the
25 medication from the Pyxis machine; and

26 c. In the alternative, Respondent failed to secure her passcode so that it could not be
27 used by others.

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23. Complainant refers to and incorporates all the allegations contained in paragraphs 13
19, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 323699, issued to Mary
Eden Robles aka Mary Eden V. Monroyo;
2. Ordering Mary Eden Robles aka Mary Eden V. Monroyo to pay the Board of
Registered Nursing the reasonable costs of the investigation and enforcement of this case,
pursuant to Business and Professions Code section 125.3;
3. Taking such other and further action as deemed necessary and proper.

DATED: SEPTEMBER 17, 2012

for 
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2011801619